State Employee Health Plan

Retiree/Direct Bill Members

Choose Your Health Benefits

Open Enrollment 2014

- ✓ Review the information in this book .
- ✓ Read ***Highlights and Reminders for Plan Year 2014*** on page 6.
- ✓ Attend an open enrollment meeting in my area – check the schedule on pages 4 and 5 for dates and times.
- ✓ **IF I DO NOT WANT TO CHANGE MY CURRENT COVERAGE**, I do not need to do anything. The coverage I selected for Plan Year 2013 will continue for Plan Year 2014.
- ✓ **TO MAKE CHANGES TO MY COVERAGE FOR PLAN YEAR 2014,** I need to enroll on-line by going to ***www.hrissuite.com*** Enrollment instructions are in the back of this booklet.
- ✓ **IF I CURRENTLY HAVE SILVERSCRIPT MEDICARE PART D PRESCRIPTION DRUG COVERAGE**, I will need to select another Part D Prescription Drug plan for Plan Year 2014.

Plan Year 2014 Open Enrollment is November 1st - 30th, 2013.

Enrollment must be completed online by midnight NOVEMBER 30, 2013.

Open enrollment elections are effective January 1, 2014.

***Cover photo is titled "Road into the Field" from the Postcards from Kansas collection by Dave Leiker.*

Kansas
Department of Health and Environment
Division of Health Care Finance

Contact Information

State of Kansas Health Plan Vendors Website	www.kdheks.gov/sehp/vendors.htm
Blue Cross and Blue Shield of Kansas	www.bcbsks.com/CustomerService/Members/State
Customer Service - Plan A, Plan B and Plan C	All Areas (Toll Free): 800-332-0307 In Topeka: 785-291-4185
Kansas Senior Plan C	All Areas (Toll Free): 800-332-0307 In Topeka: 785-291-4185
New Directions (Behavorial Health)	All Areas (Toll Free): 800-952-5906 In Topeka: 785-233-1165
CVS Caremark Prescription Drug Plan	www2.caremark.com/kse/
Customer Service - Plan A, Plan B and Plan C	All Areas (Toll Free): 800-294-6324 TDD (Toll Free): 800-863-5488
Caremark Connect Specialty Pharmacy	All Areas (Toll Free): 800-237-2767
Coventry	www.chckansas.com
Customer Service - Plan A, Plan B and Plan C	All Areas (Toll Free): 855-326-2088
Coventry Advantra Freedom PPO	All Areas (Toll Free): 800-727-9712 TDD (Toll Free): 866-347-2459
Behavioral Health (MHNet)	All Areas (Toll Free): 866-607-5970
Delta Dental of Kansas, Inc. Dental Plan	www.deltadentalks.com
Customer Service	All Areas (Toll Free): 800-234-3375 Wichita: 316-264-4511
Direct Bill Membership	
State Employee Health Benefits Plan - For Enrollment, Qualifying Event, Report a Death, Address Changes	All Areas (Toll Free): 866-541-7100 In Topeka: 785-296-1715
First Health Part D Medicare Drug Plan - **NEW**	All Areas (Toll Free): 888-736-3133
Specialty Mail Order	All Areas (Toll Free): 866-308-7548
Hewlett Packard Member Services	
Billing	All Areas (Toll Free): 866-688-5009
HealthQuest	
Customer Service	All Areas: 785-296-5624
KPERS	
Kansas Public Employee Retirement Systems	All Areas (Toll Free): 888-275-5737 In Topeka: 785-296-6166
Preferred Lab Benefit Program	
• **Quest Diagnostics Lab Card Program**	www.labcard.com
Customer Service	All Areas (Toll Free): 800-646-7788
Collection Site Listings	www.labcard.com/collection.html
• **Stormont-Vail Regional Lab Program**	www.stormontvail.org/stateemployeeslab
Customer Service	All Areas (Toll Free): 800-637-4716
Benefit Information and Collection Site Listings	Topeka: 785-354-1150
Superior Vision Services Vision Plan	www.superiorvision.com
Customer Service – Billing	All Areas (Toll Free): 800-507-3800
UnitedHealthcare	www.welcometouhc.com/kansas
Customer Service - Plan A, Plan B and Plan C	All Areas (Toll Free): 866-799-1324
Plan A, Plan B and Plan C	

CONTENTS

Take advantage of the information available online 24/7 on our Open Enrollment website.
Go to **www.kdheks.gov/hcf/sehp/directbill.htm**
On this site, you can view your 2014 open enrollment plan options, other benefits communications and more!

Direct Bill Call Center

Outside Topeka: 1-866-541-7100 | In Topeka: 1-785-296-1715

The information in this booklet is intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace the legal plan document (Benefit Description), which contains the complete provisions of a program. In case of any discrepancy between this booklet and the legal plan document, the legal plan document will govern in all cases. You may review the legal plan document upon request or go to ***www.kdheks.gov/hcf/sehp/BenefitDescriptions.htm***
Benefit Descriptions are listed under each carrier.

2014 Direct Bill/Retiree Open Enrollment Meeting Schedule

Emporia Wednesday, October 16 **10:00 a.m.**	**Flint Hills Technical College** 3301 W. 18th Avenue
Hays Monday, October 14 9:00 a.m. and 1:00 p.m.	**Kansas Highway Patrol** Basement Mtg. Rm 1821 Frontier Road
Hutchinson Tuesday, October 15 2:00 p.m.	**Kansas Department of Transportation Area Office** Conference Room 500 N. Hendricks
Lawrence Thursday, October 24 9:30 a.m. and 1:30 p.m.	**4-H County Fairgrounds** Building 21 2101 Harper Building
Manhattan Thursday, October 17 9:30 a.m. and 1:30 p.m.	Fairgrounds - **Cico Park** Konza Room - **Pottorf Hall** 1710 Avery Drive
Osawatomie Tuesday, October 15 9:00 a.m. and 1:00 p.m.	**Osawatomie State Hospital** Sunflower Room Highway 169-South 500 State Hospital Drive
Overland Park Friday, October 25 9:30 a.m. and 1:30 p.m.	**KU Edwards Campus Regents Center** Rm110 126th & Quivera
Pittsburg Thursday, October 24 9:00 a.m. and 1:00 p.m.	**Homer Cole Community Center** Conference Room 3003 N. Joplin
Pratt Tuesday, October 15 9:00 a.m.	**Community Center** Large Room 619 N. Main

Salina Wednesday, October 16 9:00 a.m. and 1:00 p.m.	**KSU-Salina College Center** Conference Room 2310 Centennial Road
Topeka Monday, October 21 8:30 a.m. and 12:30 p.m.	**Topeka and Shawnee County Public Library** Marvin Auditorium Rooms A, B & C 1515 W 10th Street
Topeka Tuesday, October 22 8:30 a.m. and 12:30 p.m.	**Topeka and Shawnee County Public Library** Marvin Auditorium Rooms A, B & C 1515 W 10th Street
Topeka Wednesday, October 23 8:30 a.m. and 12:30 p.m.	**Topeka and Shawnee County Public Library** Marvin Auditorium Rooms A, B & C 1515 W 10th Street
Wichita Wednesday, October 23 9:00 a.m. and 1:00 p.m.	**Holiday Inn Select** North Ballroom 549 S. Rock Road

Highlights and Reminders for Plan Year 2014

WHAT'S NEW

- **Autism Spectrum Disorder coverage** is now a permanent benefit. Coverage details are in the benefit description.
- **Coverage for Bariatric Service for qualified patients.** Coverage details are in the benefit description.

WHAT'S CHANGING

HEALTH PLANS:

Plans A and B ONLY -

- Urgent Care facility visits - office charge will be subject to a $50 copay. Additional testing, sutures or other services will be subject to deductible and coinsurance.
- Deductible, Copays and Coinsurance apply to the Out of Pocket (OOP) maximum - See Comparison Chart.
- Annual Coinsurance and Copay maximum has increased - See Comparison Chart.

Plans A, B and C - Plan Design Changes

- Removal of the dollar limit on durable medical equipment
- Preventive Care Adjustments:
  - Well Woman Care
    - Add coverage for OTC contraceptives, if prescribed
    - Add coverage for BRCA gene testing for breast cancer
    - Add HIV testing for sexually active women
  - Polyp removal during colonoscopy is now included
  - Coverage for aspirin prescribed to reduce heart attacks

PRESCRIPTION DRUG COVERAGE

Plans A and B - Non preferred drugs will be counted toward meeting the coinsurance maximums in PY2014, Coinsurance Maximums will be as follows:

- Individual will be increased to $2,750
- Family will be set at $5,500 - **NEW**

MEDICARE PART D PRESCRIPTION DRUG COVERAGE

SilverScript Medicare Part D will not be offered in Plan Year 2014. First Health Part D, from Coventry Health Care is the new fully insured Medicare Part D prescription drug plan. **First Health will bill members directly for this coverage.**

REMINDERS

- **Enrollment will be completed online for Plan Year 2014.** Instructions are on pages 28-29 of this booklet.
- **If you do not want to make any changes to your coverage for Plan Year 2014, you do not need to do anything.** Your Plan Year 2013 selection will continue through Plan Year 2014.
  NOTE: If you are currently enrolled in SilverScript and do not make a Medicare Part D election during Open Enrollment, you will automatically be switched to First Health Part D for Plan Year 2014.

- **Members can opt out of Delta Dental Coverage only during the Open Enrollment period. NOTE:** Once a member opts out of dental coverage, they will not be able to re-enroll in dental coverage at a later date.
- **Members can opt out of Superior Vision coverage only during the Open Enrollment period.**
- **If you decide to opt out of the Part D prescription drug coverage offered through the State Employee Health Plan**, you must have "creditable drug coverage" from the "Private Market" to be eligible to return to the SEHP Part D coverage during Open Enrollment without having to pay a penalty. "Private Market" Open Enrollment for Part D prescription drug coverage is October 15th through December 7th.

- **If you will be receiving Medicare due to a disability,** contact Membership Services at 866-541-7100 (outside Topeka) or 785-296-1715 (in Topeka).
- **If you do not pay your premiums through KPERS deduction** - All SEHP premium payments (except First Health Part D which will be billed by First Health) should be sent to the 3rd Party Billing Administrator for Retiree/Direct Bill participants, **Hewlett Packard (HP)** at HP Kansas Premium, P.O. Box 842195, Dallas, Tx 75284. Also, if you need information for your federal income taxes, you can call HP at **866-688-5009**.

Direct Bill Member Eligibility

An individual is eligible for participation in the State Employee Health Plan as a Direct Bill member if he or she is:

- A retired official or member who is eligible for a retirement benefit through the State of Kansas.
- A totally disabled former State official or member who is receiving a disability benefit through the State of Kansas.
- A former elected State official who was covered under the State plan immediately before the date the person ceased to be an elected official.
- A blind person licensed to operate a vending facility, or any licensed blind person who has ceased to operate a vending facility.
- A surviving spouse or dependent of a former State member or retiree. The spouse or dependents must have been covered under the State plan immediately before the date of death of the member or retiree.
- An active State member who was covered under the State plan immediately before going on approved leave without pay. Participation due to leave without pay status is limited to one year.

Open Enrollment

The Annual Open Enrollment period for State Employee Health Plan Retiree/Direct Bill members is November 1st through November 30th.

If you do not want to make any changes to your coverage for Plan Year 2014, you do not need to do anything. Your Plan Year 2013 selection will continue through Plan Year 2014. **NOTE:** If you are currently enrolled in SilverScript and do not make a Medicare Part D election during Open Enrollment, you will automatically be switched to First Health Part D for Plan Year 2014.

If you have questions, please contact the Direct Bill Call Center toll free at 1-866-541-7100 or 296-1715 (In Topeka). Representatives are available to assist you from October 21, 2013 through January 3, 2014, Monday through Friday 8:30 a.m. to 4:30 p.m. Central time. **The office will be closed** on VeteransDay (November 11), the Thanksgiving Holiday (November 28-29), Christmas Holiday (December 25) and New Year's Holiday (January 1, 2014).

Any changes made to your health plans during the open enrollment period will become effective January 1, 2014.

How to Enroll

Review all of your enrollment materials including this Open Enrollment booklet or go to ***www.kdheks.gov/hcf/sehp/directbill.htm*** to become familiar with your options.

Read *Medicare and You*, a handbook from the Social Security Administration, if you or a covered dependent is eligible for Medicare.

Attend an Open Enrollment Meeting. If you are enrolling during the annual open enrollment period, we encourage you to attend an Open Enrollment Meeting to hear explanations of your benefit options and to ask questions. See pages 4-5 for dates and times of meetings near you.

Learn about your health plan options. Make sure your health care providers, medical facilities and pharmacy are included in your health plan's network of preferred providers.

If you want to make changes to your coverage for Plan Year 2014, you need to do this on-line at ***www.hrissuite.com*** using the instructions on pages 28 - 29 of this book.
Enrollment must be completed NO LATER THAN NOVEMBER 30, 2013.

Choosing Your Health Plan:

Plan A, Plan B, Plan C, Kansas Senior Plan C or Coventry Advantra Freedom PPO

You have choices when it comes to your health coverage. Choosing the appropriate health plan for you and your family may be easier than you think!

The State offers the following plans to Direct Bill members:

- **Plan A** — Blue Cross and Blue Shield of Kansas, Coventry, or UnitedHealthcare
- **Plan B** — Blue Cross and Blue Shield of Kansas, Coventry, or UnitedHealthcare
- **Plan C High Deductible Health Plan (HDHP)** — Blue Cross and Blue Shield of Kansas, Coventry, or UnitedHealthcare
  NOTE: A Health Savings Account is **not** available for retirees electing Plan C (HDHP) under Direct Bill.
- **Coventry Advantra Freedom PPO** (with Coventry Part D)
- **Coventry Advantra Freedom PPO** (with First Health Part D**)**
- **Kansas Senior Plan C** (with or without First Health Part D**)**

Reminder: Kansas Senior Plan C is the **ONLY** plan Direct Bill members can enroll in without Prescription Drug coverage and select a Part D prescription drug plan from the Private Market.

I**f you elect to enroll in Kansas Senior Plan C and do not take Prescription Drug coverage under the State plan**, **and** do not enroll in Part D prescription drug coverage from the Private Market, you may re-enroll in the State's Part D Prescription Drug Coverage during the next open enrollment period or if you have a qualifying event, but you will pay a penalty.

When making your health plan choices, Direct Bill members should always consider present health conditions and the financial status of all individuals to be covered under the chosen plan.

Direct Bill members and their dependents generally fall into two categories: Non-Medicare eligible and Medicare eligible.

- **Non-Medicare eligible members and their dependents** may choose between three traditional health plans: Plan A, Plan B or Plan C (HDHP). These plans have the same prescription drug coverage offered by CVS/Caremark.
- **Medicare eligible individuals** may choose between the three traditional health plans: Plan A, Plan B or Plan C (HDHP) with prescription drug coverage offered by CVS/Caremark. Members may be able to save money on premiums and/or out-of-pocket costs if they choose one of the Medicare options:
  - Coventry Advantra Freedom with Coventry Part D
  - Coventry Advantra Freedom with First Health Part D
  - Kansas Senior Plan C with or without First Health Part D

Non-Medicare Options
Plan A, Plan B or Plan C (HDHP)

You have access to all health plans regardless of where you live.

You have choices when it comes to your health care coverage. Choosing the appropriate health plan for you and your family may be easier than you think!

The State Employee Health Plan offers three medical plan options:

- Plan A
- Plan B
- Plan C - High Deductible Health Plan (HDHP)

Each option is designed differently (for example, deductibles, coinsurance and annual maximums). Please review Comparison Chart 1 *Plans A, B and C* to see the differences.

The Preferred Lab Benefit program is available with either Plan A or Plan B **only**. See page 11 for details.

There are three health plan vendors:

- Blue Cross and Blue Shield of Kansas
- Coventry
- UnitedHealthcare

Each health plan vendor has a different network of preferred providers. Since network providers have agreed to accept the plan allowance as payment in full, using network providers saves you money! Non network providers have not agreed to accept the plan allowance so any amount above the plan allowance will be your responsibility. In addition, each health plan vendor offers unique features to consider before making your selection. You can review the provider directories at: ***www.kdheks.gov/hcf/sehp/VendorProviderDirectories.htm***

All options offer the following:

- Access to a broad network of providers nationwide which allows you flexibility in obtaining care with coverage for both network and non network providers.
- 100 percent coverage for certain preventive care services, such as annual exams, colonoscopy screenings, mammograms and age-appropriate immunizations (including flu shots and allergy shots).
- No dollar limit on the care you may need during the lifetime of the policy.
- Prescription drug coverage through Caremark. See page 12 for details.

Preferred Lab Benefit
Available with State Plans A & B Only

Members will get 100% coverage of routine and diagnostic outpatient lab tests. All you need is your Plan Year 2014 State Employee Health Plan ID card identifying your membership in either Plan A or B. Quest and Stormont-Vail logos will be printed on this ID card.

Quest Diagnostics offers collection sites at various locations throughout the State of Kansas and nationwide. Also, you can arrange to have specimens picked up from your doctor's office. All it takes is a telephone call to the number on the back of your ID card.

Stormont-Vail Health*Care* offers 8 locations in northeast Kansas, for ALL State Employee Health Plan members. You do NOT have to be a Cotton O'Neil patient to access this benefit. Just bring the lab orders from your physician.

For details on the Preferred Lab Benefit go to
www.kdheks.gov/hcf/sehp/PreferredLab.htm

PLEASE REMEMBER:

You must verbally request to use your Preferred Lab Benefit.

The Preferred Lab Benefit Program does NOT cover:

- Testing ordered during hospitalization
- Lab work needed on an emergency or STAT basis
- Testing done at any other laboratory
- Non-laboratory work such as mammography, x-rays, imaging and dental work
- Time sensitive, esoteric testing such as fertility testing, bone marrow studies and spinal fluid tests
- Testing not approved and/or covered by the State of Kansas Plans A or B
- Lab work billed to your health plan by your doctor or another laboratory

The Preferred Lab Benefit is completely voluntary.
If you and your health care provider choose to use a lab other than those provided by either Quest Diagnostics or Stormont -Vail Health*Care*, you still have laboratory coverage. However you will be responsible for any deductible, copayments or coinsurance applied by the health plan.

Caremark Prescription Drug Plan
Available with State Plans A, B, and C

Prescription drug coverage is provided through Caremark for Plans A, B and C, and its cost is included in the health plan rates. While the Preferred Drug List (PDL) is the same for all plans, the amount you pay will vary depending on the plan you select as explained below.

- **Plan A and Plan B.** Under these plans, generally you pay a coinsurance for your prescription drug costs throughout the year, up to a combined coinsurance maximum of $2,750 for single and $5,500 for member **(new this year)** with dependent coverage per year.
- **Plan C.** Until you reach the deductible, you will pay 100% of the discounted cost for your prescriptions when you present your Caremark ID card. Once you have reached your annual health plan deductible, covered prescriptions are paid in full by the plan when a network pharmacy is used. Review the health plan comparison chart for more information.

Before talking to your physician about prescriptions, it is suggested that you print out the Preferred Drug List (PDL) from the website and take it with you so you can discuss your options. If the physician says you must take a brand name drug, ask if there is a preferred brand name drug listed on Caremark's PDL that would work for you. Regardless of which plan you elect, your out-of-pocket costs will be lower if you use generic and/or preferred brand name drugs.

This PDL is updated quarterly and is available at either of the following websites:

- ***www2.caremark.com/kse***
- ***www.kdheks.gov/hcf/sehp/Caremark.htm***

You can also call Caremark at **1-800-294-6324**, so please check for updates throughout the year. A number of popular name brand drugs are projected to be available in generic versions during 2014. The list of generics is also on these websites.

The Caremark plan is designed to encourage you and your health care provider to choose the most cost-effective and clinically-effective medications available. Home delivery is available through Caremark and reorders are processed in as little as 5 to 7 days. To place an initial order or to reorder by phone, call **1-800-294-6324** or e-mail ***online@caremark.com***

Specialty and biotech drugs are designed for difficult conditions that don't respond to traditional therapy, and are available only at the Caremark Connect Specialty Pharmacy. Contact Caremark Connect at **1-800-237-2767.** A Caremark representative will coordinate patient care with the provider and arrange overnight shipping.

For more details on prescription drug benefits go to ***www.kdheks.gov/hcf/sehp/Caremark.htm***

Direct Bill Members and Dependents Eligible for Medicare

The retiree and any Medicare Eligible Dependents must be enrolled in Medicare Part A and Medicare Part B. For more information on Medicare, please go to page 20.

Many Direct Bill members are eligible for benefits under Medicare. Medicare enrollment may be achieved when an individual reaches age 65 or becomes disabled and is deemed eligible for Medicare by the Social Security Administration. Additional information about enrolling in Medicare may be obtained by calling **1-800-633-4227**, visiting your local Social Security Office or accessing the Medicare website at ***www.medicare.gov*** In any event, you should contact Social Security three months before you turn age 65.

Medicare Components

Medicare is comprised of four components. A short explanation of each component is provided below:

- **Part A—Hospital Insurance.** Medicare Part A helps pay for medically necessary care in hospitals, nursing homes following a hospital stay (not custodial or long term care), home health care, hospice care and blood transfusions.

- **Part B—Medical Insurance.** Medicare Part B helps pay for physician's services, outpatient hospital services, emergency room care, diagnostic tests, durable medical equipment, ambulance services, 80 percent of the Medicare-approved amount for blood, starting with the fourth pint, and many other health services and supplies not covered by Medicare Part A.

  Medicare Part B enrollees pay a monthly premium to Social Security.

- **Part C—Medicare Advantage Plans.** Medicare Part C (Medicare Advantage Plans) are arrangements between Medicare and private insurance companies for providing your Medicare Part A and Part B benefits as well as additional benefits to Medicare beneficiaries through an insurance company. In Medicare Advantage Plans, you pay the basic Medicare Part B premium **and** pay an additional premium to the Medicare Advantage Plan.

- **Part D—Prescription Drug Coverage.** Medicare Part D is designed to assist in the payment of prescription drug costs. The program, which became effective on January 1, 2006, is administered through private insurance companies. Medicare recipients may enroll in Medicare Part D programs when they become Medicare eligible or during the annual enrollment period from October 15 - December 7. Additional information about Medicare Part D may be obtained from the *Medicare and You* handbook issued annually, by calling Medicare at 1-800-633-4227or by going online to ***www.medicare.gov***

Medicare Supplement Plans

As noted earlier, Medicare Part A and Part B do not pay 100 percent of health care costs. Both have deductibles and coinsurances which must be paid by the beneficiaries in addition to the monthly premium. Medicare supplement programs are designed to supplement Medicare coverage by paying these additional charges. Enrollees in Medicare supplement plans pay an additional monthly premium to the insurance provider offering the plan.

State of Kansas Health Care Plans for Medicare Eligible Members, Spouses and/or Dependents

The State of Kansas offers health care plans designed to work with Medicare. The differences between the plans include how the services are delivered and how much you have to pay out of your own pocket. You pay a monthly premium for each of these plans.

In addition to deciding which health care plan is best for your situation, you should also decide which prescription drug coverage you wish to enroll in. The Advantage plan offers two prescription drug options. The Medicare Supplement Plan offers coverage with or without Prescription Drug Coverage.

The plans are:

- **Medicare Supplement Plan.** The State of Kansas offers Kansas Senior Plan C as a Medicare supplement. Under this plan, when you visit a facility or physician that accepts Medicare assignment, Medicare is billed first for the services. Any remaining balance is covered in full by Kansas Senior Plan C. The plan is available without optional prescription drug coverage or with First Health Part D, an optional Medicare Part D component. Additional information about Kansas Senior Plan C may be found on page 15.

- **Medicare Advantage Plan.** Coventry Advantra Freedom Preferred Provider Organization (PPO). With this option, you will have copays for certain services.

Like all PPO plans, the Coventry Advantra Freedom PPO uses physicians, specialists and hospitals that are included in the particular plan's network of preferred providers. You can go to medical professionals not in the network, but it may cost extra. You do not need referrals to see medical professionals who are not part of the network.

The Coventry Advantra Freedom plan has a Part D plan included in the premium or is available with First Health Part D prescription drug coverage. (See pages 16-17 for more information about the Coventry Advantra Freedom plan).

Regardless of the medical plan chosen, the dental and vision plans offered by the State of Kansas to Direct Bill members are identical. Prescription drug plans offered to Direct Bill members and/or dependents who are Medicare eligible are discussed within the specific plan explanation.

Kansas Senior Plan C

Kansas Senior Plan C is a State of Kansas Medigap policy administered by Blue Cross and Blue Shield designed to lower costs for Medicare eligible Direct Bill members, spouses and/or dependents.

With Kansas Senior Plan C, members can choose the plan that includes First Health Part D prescription drug coverage or they can choose Kansas Senior Plan C without drug coverage and purchase prescription drug coverage under Medicare Part D on the Private Market.

- Kansas Senior Plan C is one of the 10 standardized Medicare supplement insurance plans. It has the same medical benefits as any other Medicare Supplement Plan C. Medicare Supplement Insurance exists to help fill the gaps that Medicare approves but does not pay. Unlike individual medigap policies such as Plan 65, Kansas Senior Plan C is group rated rather than individually age rated. Kansas Senior Plan C offers optional prescription drug, dental and vision benefits while most individual policies offer only medical benefits. The retiree and any Medicare Eligible Dependents must be enrolled in Medicare Part A and Medicare Part B. There is no network for physicians or hospitals.

  Kansas Senior Plan C is the only plan offered to Direct Bill members that allows the member to elect Part D coverage from the Private Market.

- The medical portion of the plan pays what Medicare approves but does not pay. This includes both the Part A and Part B deductibles each year, as well as any coinsurance required by Medicare coverage rules. **Important Note**: If Medicare does not cover a service, there is no benefit under the medical portion of Kansas Senior Plan C.

- Simply utilize providers who accept Medicare assignment. These providers agree to accept the Medicare allowance as payment in full. This means that between the Medicare payment and the Kansas Senior Plan C payment, the member has no out-of-pocket costs.

- Travel with confidence because Kansas Senior Plan C coverage is accepted by doctors and hospitals everywhere in the United States so you'll have access to care if you need it. Foreign travel emergencies are also covered with some limitations.

- Members may elect Kansas Senior Plan C coverage with or without Delta Dental coverage. **However** - once a member opts out of dental coverage, the member will not be able to re-enroll in dental coverage at a later date.

Coventry Advantra Freedom PPO

Coventry Advantra Freedom PPO is available for Direct Bill members enrolled in Medicare Part A and Part B. It is a Medicare Advantage Plan under Part C of Medicare. You have peace of mind knowing that Advantra meets all of Medicare's stringent regulations and offers you more benefits with no up front deductibles. Coventry Advantra Freedom PPO is offered with the choice of Coventry Part D or First Health Part D prescription drug coverage. "Private Market" Part D coverage is not allowed with the Coventry Advantra Freedom PPO option.

The funding that Advantra receives allows it to offer products that have more benefits than Medicare for premiums that may be significantly lower than other policies. Direct Bill members enrolled in the Advantra PPO Plan continue to pay the Part B premium and a monthly premium for the Advantra Plan. **You do not need to buy additional supplemental Medicare insurance.**

Coventry Advantra Freedom PPO is sponsored by Coventry Health Care of Kansas, Inc. The Advantra plan is filed and approved for the entire states of Kansas, Missouri, Oklahoma and Arkansas. **If you consider the Coventry Advantra Freedom PPO Plan, you need to make sure you have access to a preferred provider to receive in network services.** To view the Advantra Freedom PPO provider directory, go to ***www.coventry-medicare.com*** or contact Coventry customer service at **1-800-727-9712**.

Although this plan gives members the freedom to seek care without referral from any physician who treats people enrolled in Medicare, you will receive the highest level of benefit if you seek care from doctors who are part of the PPO network.

The PPO option includes Medicare Part D prescription drug coverage which features unlimited preferred generic drugs. You can select either Coventry Part D or First Health Part D.

Coverage under Advantra Freedom PPO also includes:

- Unlimited hospital days
- $10 copayment for Primary Care Physician and $25 Specialist office visits
- No copayments, coinsurance or deductible for preventive care services such as colonoscopy screenings, mammograms and immunizations
- Hearing and vision exams
- Access to a telephonic nurse advice line, available 24 hours a day, seven days a week
- Mail order prescription drug service available
- $0 copay for glucose meters and test strips from a preferred provider, $5 copay for test strips and supplies and 20% coinsurance from a non-preferred provider
- Cervical and Vaginal Cancer Screening - every two years as mandated by

CMS. Covered once a year for women with Medicare at high risk.

- Network - Stormont Vail/Cotton O'Neil and St. Francis will be available for members in 2014.

If you use medical services, the Advantra Freedom PPO limits the out-of-pocket cost a member will pay for health care services to $1,000 per year for network services, excluding prescription drugs (see Summary of Benefits for details). Once this level is reached, Advantra will cover applicable medical services at 100 percent. The out-of-pocket maximum resets to zero each year on January 1.

The out-of-pocket maximum does not apply to services provided outside the PPO network.

Members may elect the Coventry Advantra Freedom PPO with or without Delta Dental coverage. **However -** once a member opts out of dental coverage, the member will not be able to re-enroll in dental coverage at a later date.

Additional Coventry Advantra Freedom Services

Coventry Advantra offers members the SilverSneaker Program- providing unlimited access to participating fitness centers anywhere in the country at no extra charge.

First Health Part D Medicare Drug Plan - NEW

First Health Part D is an optional Medicare Part D prescription drug component. This plan is being offered to you by the State of Kansas and provides a level of benefits not available on standard Part D plans. found on the private market.

For questions concerning First Health Part D coverage, members should contact First Health Part D Customer Care representatives at **1-888-736-3133**. The benefit specialists are available from 8:00 a.m. to 8:00 p.m. Monday - Friday. They can assist with questions reagrding the transition to your new plan, drug cost estimations and answer any questions you may have.

How Medicare Part D Works

Medicare Part D began in 2006 and is designed to assist Medicare beneficiaries in paying the cost of medically-necessary prescription drugs. To get Medicare coverage for your prescription drugs, you must choose and join a Medicare prescription drug plan.

Regardless of how a Medicare prescription drug plan offers this coverage, there are some key factors that may vary. Some of these factors might be more important to you than others, depending on your situation and drug needs. Some of these factors are:

- **Premium Cost.** All plans require payment of a monthly premium.
- **Deductible.** This is the amount you pay for your prescriptions before your plan starts to share in the costs. Deductibles vary by plans. **First Health Part D, unlike many other plans, does not have a deductible.**
- **Copayment/Coinsurance.** This is the amount you pay for your prescriptions. In some plans, you pay the same copayment (a set amount) or coinsurance (a percentage of the cost) for any prescription. In other plans, there might be different levels with different costs. (For example, you might have to pay less for generic drugs than brand name drugs. Or, some brand name drugs might have a lower copayment than other brand name drugs.) Also, in some plans your share of the cost can increase when your prescription drug costs reach a certain limit.
- **Formulary.** A formulary is a list of drugs covered by a specific Medicare prescription drug plan. Formularies include generic and brand-name drugs. The formulary varies, but all plans must include at least two drugs in categories and classes of most commonly prescribed. This ensures that people with different medical conditions can get the treatment they need. First Health Part D uses a formulary. Your drugs must be on the formulary in order to be covered. In the event you take a drug that is not on the formulary, it is possible that an exception may be granted. Contact First Health Part D at **1-888-736-3133** for more information on the exception process or formulary. You can find the formulary online at ***www.kdheks.gov/hcf/sehp/Vendors/First HealthPartDRx.htm***
- **Prior Authorization.** Some drugs are more expensive than others even though some less expensive drugs work just as well. Other drugs may have more side effects, or have restrictions on how long they can be taken. To be sure certain drugs are used correctly and only when truly necessary, plans may require a "prior authorization." This means before the plan will cover these prescriptions, your doctor must first contact the plan and show there is a medically-necessary reason why you must use that particular drug for it to be covered. Plans might have other rules like this to ensure that your drug use is effective.
- **Coverage Gap.** If you have high drug costs, you may want to consider the state's First Health Part D prescription drug plan. This plan does not have a deductible and pays through the coverage gap, unlike plans offered on the Private Market. **NOTE:** CMS requires the accumulation of your true out-of-pocket (also known as TrOOP) cost includes Medicare Coverage Gap Discount Program, 50% discount by the manufacturer and your out of pocket cost for the prescription at the pharmacy. This accumulation may push you through the Coverage Gap sooner than in previous years. Please watch your ***Explanation of Benefits*** from First Health Part D to assist you in knowing when you will hit Catastrophic Coverage.
- **Catastrophic Coverage.** Once your TrOOP cost reaches $4,550.00 for the year, you will move to the catastrophic coverage level. Don't forget this amount represents what You, the member AND others pay on your behalf. During Catastrophic Coverage, you will pay no more than the greater of 5% coinsurance or $2.55 for generics and $6.35 for all other drugs. If you are

taking a Tier 5 Specialty Drug, you may want to review this change as it could result in higher out-of-pocket cost for you. This plan does not have a cap for Catastrophic Coverage.

First Health Part D Overview

First Health Part D **will generally** cover the drugs listed in their formulary as long as:

- The drug is medically necessary
- The prescription is filled at a Network pharmacy, and other coverage rules are followed.

First Health Part D does **not** pay for drugs that are covered by Medicare Part B, such as:

- Drugs usually supplied by and administered in your doctor's office (such as chemotherapy drugs)
- Drugs used with durable medical equipment (DME) that you obtained through DME services, such as respiratory drugs given through a nebulizer
- Some immunosuppressive drugs (if you had a Medicare covered transplant) and some oral anti-cancer drugs
- Drugs provided in Hospital Outpatient Departments and drugs such as erythropoietin (EPO) if you are undergoing dialysis

REMINDERS

In order to participate in Medicare Part D, you must enroll in only **one** of the Part D plans. Once you are enrolled in a plan (either through the State Employee Health Plan or the private market), if you should enroll in another Medicare Part D plan at a later date, you will be automatically dis-enrolled in the previous plan enrollment.

This is important to know because if you are enrolled in a Medicare Part D plan that is coupled with other health insurance, enrollment in a subsequent Part D plan may result in loss of your health insurance benefits.

Retirees that do not wish to make any changes to their SEHP coverage for Plan Year 2014 **but** are currently enrolled in the State of Kansas SilverScript Plan will automatically be switched to First Health Part D for Plan Year 2014.

If you do not want to participate in First Health Part D, you must contact the Direct Bill Call Center at 1-866-541-7100 (In Topeka 296-1715). Representatives are available to assist you from October 21, 2013 through January 3, 2014, Monday through Friday 8:30 a.m. to 4:30 p.m. Central time. The office will be closed on Veterans Day (November 11), the Thanksgiving Holiday (November 28-29), Christmas Holiday (December 25) and New Year's Holiday (January 1, 2014).

If, in the past, you have been eligible for a Medicare Part D plan and were not enrolled in a State of Kansas prescription drug plan, you must provide a letter of creditable prescription drug coverage before November 30, 2013 in order to enroll in First Health Part D.

Medicare Eligibility

Medicare is a federal health plan designed for the elderly and disabled. It assists enrollees in the payment of health costs subject to certain copays and/or coinsurances. A person may be eligible for Medicare by virtue of reaching age 65 or by being approved for total disability by the Social Security Administration.

Medicare consists of several components including Part A Hospitalization and Part B Medical. Medicare is described in detail in the *Medicare and You* handbook available by calling **1-800-633-4227** or from a local Social Security Office. You can also access Medicare information at ***www.medicare.gov***

Direct Bill members eligible for Medicare, either as a result of age or approved disability, are subject to certain rules and conditions that differ from other Direct Bill members. This section of the book focuses on these rules and conditions as well as pointing out information that is important to Medicare eligible Direct Bill members.

Medicare Member Definition

"Medicare member" is a member in the State Employee Health Plan who is also eligible for Medicare benefits. For these members, Medicare is the primary payer of medical benefits. The member's or covered spouse's status will be changed during the year when he or she is first eligible for Medicare. This is not just an Open Enrollment change.

Coverage Information

Medicare eligible members who are enrolled in State Plans A, B or C (HDHP) will receive the same benefits as active members, provided their doctor accepts Medicare assignments.

The other plans designed specifically to work with Medicare, Kansas Senior Plan C or Coventry Advantra Freedom, offer low-cost, high value health insurance coverage. Although dental coverage is not offered through Medicare, the State of Kansas Health Plans offer dental coverage for its members.

Coverage Conditions

1. **Over Age 65 or otherwise Medicare Eligible.** If a member or covered spouse is age 65 or older, he or she will be considered an eligible Medicare member even if they do not elect coverage under Medicare. Claims will be processed as if the member or spouse is enrolled in both Parts A and B of Medicare, even if Medicare Part A is not free or if he or she does not sign up for Medicare Part B. For this reason, it is very important that the member or spouse applies for Medicare, both Parts A and B, when first eligible and no longer actively employed with the State of Kansas. To receive full benefits, an individual who does not have sufficient quarters to qualify or who does not qualify through his or her spouse for free Part A coverage, must purchase Part A coverage. It is the member's responsibility to work with his or her local Social Security office to enroll for the proper levels of Medicare coverage. The member and/or covered spouse must send a copy of the Medicare card to the Direct Bill Membership Office at Room 900-N, LSOB, 900 SW Jackson Street, Topeka, Kansas 66612.

2. **Under Age 65 and Disabled.** If a member or covered spouse under age 65 has been approved for total disability by the Social Security Administration, he or she will be considered a Medicare member following 24 months from the date of total disability. When under age 65 and covered by Medicare, the member or covered spouse must send a copy of the Medicare card to the Direct Bill Membership Office.

Delta Dental Plan

Important Note: Members may elect to opt out of Delta Dental coverage. However, once a member opts out, the member will **not be able to re-enroll** in dental coverage at a later date.

Member only dental coverage is an option for all members enrolled in medical coverage. If you choose to enroll your dependents in dental coverage the same dependents enrolled in dental coverage must be enrolled in medical coverage. Dependent dental coverage may not be dropped **during the plan year** unless dependent medical coverage is also dropped.

You have access to two Delta Dental provider networks.

Delta Dental Premier Network

The Delta Dental Premier Network is the broad network of providers that you may use. Delta Dental will make payment directly to the dental provider. You will be responsible only for paying the specific coinsurance and deductibles for covered services in addition to any services not covered. Delta Premier Dentist agree to accept the plan allowance as payment in full.

Delta Dental PPO Network

Delta Dental also offers the Delta Dental PPO network. The PPO network providers have agreed to a reduced fee for providing dental services. As a result, you generally pay a lower percentage of the total bill than you would when using the Premier Network. The PPO network for our group includes all PPO providers in the national DeltaUSA PPO network. Again, all participants in the Delta Dental program may use the PPO providers whenever desired.

Preventive Care

Diagnostic and preventative services are covered at 100% with no deductible. Covered services include:

- Prophylaxis/cleanings – twice per plan year.
- Oral examinations – twice per plan year.
- Bitewing x-rays –
  - adults - once per plan year
  - children under 18 - twice per plan year
- Full mouth x-rays – once each five (5) years.
- Limited coverage for children only:
  - Sealants
  - Space maintainers
  - Topical fluoride
- Ancillary – emergency relief of pain.

Plan Deductibles

A deductible of $50 per person with a maximum annual family deductible of $150 applies to all basic and major restorative care. This includes:

Basic Restorative

- Regular restorative dentistry - fillings
- Oral surgery
- Endodontics – root canals
- Periodontics – treatment of gum and bone disease
- Additional diagnostic X-rays

Major Restorative

- Special restorative dentistry – crowns
- Prosthodontics – bridges, implants and dentures
- TMJ Treatment – requires prior authorization

A $1,000 per person per lifetime benefit applies to orthodontic benefits, and there is an annual benefit maximum of $1,700 per person per year for all dental services except orthodontics. Implants have a limited coverage of up to a maximum of $1,250 per year. See the Benefit Description for limitations or exclusions of the plan.

Enhanced & Basic Coverage

Preventive Care Services are always covered at 100 percent of the allowed amount. Ninety days after a preventive office visit or cleaning, the member is eligible for the enhanced benefit level. If the member has had at least one routine prophylaxis (cleaning) and/or preventive oral exam in the preceding 12 months, basic restorative services are subject to a coinsurance of 20% when provided by a PPO provider and 40% coinsurance when provided by a Premier or Non Network provider. Major restorative services are covered at the 50% coinsurance rate for all providers.

The basic benefit applies when the member has not had at least one routine prophylaxis (cleaning) and/or preventive oral exam in the prior 12 months. The member is responsible for paying 50% coinsurance for all basic and major restorative services, regardless of provider. For those at the basic benefit level, you must wait 90 days from your cleaning or exam to qualify for the enhanced benefit level.

For more details on dental benefits go to ***www.kdheks.gov/hcf/sehp/Delta.htm***

Superior Vision Services Plan

You are offered two vision plans through Superior Vision Services* — the Basic Plan and the Enhanced Plan. You may choose to enroll yourself and any eligible dependents in one of the vision plans, whether or not you or your dependents are enrolled in the health plan. If you choose dependent vision coverage, and dependent children are also enrolled in the medical plan, the dependent children enrolled in the vision plan must match those enrolled in the health plan.

Please note that you can enroll or change your coverage only when you or a dependent first becomes eligible, during the annual open enrollment period, or if a dependent becomes ineligible. **Mid-year changes to your vision coverage elections are not allowed.**

Basic Vision Plan Coverage

Exams under the Basic plan are subject to a $50 copay. A $25 material copay to lenses also applies to frame purchases but not contacts, then the policy covers:

- 100% on single-vision, standard bifocal, trifocal or lenticular lenses.
- Up to $100 retail allowance for frames
- Elective contact lens allowance of $150
- Home delivery of contacts via ***SVcontacts.com***
- Contact lens fitting benefit (with a $35 copay)

Enhanced Vision Plan Coverage

The enhanced vision plan includes all basic plan coverage, along with

- Progressive lenses covered up to $165
- High-index lenses or poly-carbonate lenses covered up to $116
- Scratch and UV coating
- Contact lens fitting fee (subject to a $35 copay with limited coverage)
- Frame allowance on Enhanced plan is now $150 retail allowance

NOTE: Enhanced benefits are **not** available from non network providers.

Special Features From Superior Vision Services

- **Discounts are available for lens add-ons or upgrades not otherwise covered by the plan.** The discount is 20 percent and is available from providers identified in the Superior Vision provider directory with a "DP."

- **Discounts on additional eye wear.** Discounts are available for additional eyewear purchases. The discounts range from 10 percent to 30 percent and are available at providers identified in the provider directory with a "DP."

- **Discounts on refractive surgeries such as LASIK, RK and PR K.** Providers listed in the provider directory with the "RF" designation will provide Superior Vision members with a discount of 20 percent on refractive surgeries.

For more details on vision benefits go to ***www.kdheks.gov/hcf/sehp/Superior.htm***

**The Superior Vision Plan is underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, aka The Guardian or Guardian Life.*

Changing Your Coverage

The coverage you are enrolled in on November 30, 2013 will become effective January 1, 2014. You may terminate coverage for you or your dependent(s) at any time. **Please remember** - If you terminate coverage, you **cannot** re-enroll in the Plan.

Important: You must notify the Direct Bill Membership Office within 31 days of a qualifying event in order for the change to be effective the first day of the month following the event. If a change is not made within this 31-day period, the change cannot be made until the next Open Enrollment period.

Refunds may not be made retroactively. If there is a qualifying event that would result in a refund and the Direct Bill Membership Office is not notified within the 31-day period, a refund may not be processed. The only exception would be death.

Qualifying events include:

- you, your spouse or dependent become Medicare eligible
- the birth or adoption of a child
- marriage
- divorce
- death of a spouse or a dependent
- gain or loss of employment and benefits for a spouse or dependent

Documentation of the qualifying event will be required before the change is made. Please send a copy of the following:

- Medicare card
- birth certificate
- marriage certificate
- death certificate
- copy of obituary

Qualifying Events

Open Enrollment is your annual opportunity to make changes to your health care coverage. Changes cannot be made to your health or dental elections until next year's Open Enrollment unless you experience a qualifying event. The effective date of change for qualifying events will be the first day of the month following the event. Qualifying events include:

- The member's marriage, final divorce or legal separation
- Birth or adoption of a dependent
- Gain or loss of legal custody of a dependent
- Change from part-time to full-time or from full-time to part-time employment by spouse which affects cost, benefit level or benefit coverage for the member and/or dependents
- Termination or commencement of employment (including retirement) of spouse or dependent which affects benefits coverage for the member and/or spouse or dependents
- Unpaid leave of absence by spouse or dependent which affects the benefits coverage for the member and/or spouse or dependent
- Significant changes during a spouse's Open Enrollment for group health insurance, such as premium increases, benefits levels or enrollment in coverage
- A member, spouse or dependent being called to active military duty
- Expiration of COBRA continuation benefits from a previous employer for the member, spouse or dependent
- The member's change in residence which requires a change in insurance plan
- Death of a spouse or dependent
- If the surviving spouse is not enrolled in dental coverage at the time of the member's death, they will have a one time option to enroll in dental coverage during the next open enrollment period
- Spouse or dependent moving out of an enrollment area, if applicable
- A dependent turning age 26
- Spouse or dependent gaining or losing government-sponsored medical card coverage
- The member, spouse or dependent becoming Medicare eligible, the effective date of the change will be the date listed on the Medicare card
- Dependent children identified under a Medical Withholding Order (K.S.A. 43-2105) or Medical Child Support Order
- Court order requiring adding or dropping coverage for a dependent
- All spouse changes as listed above but including events involving coverage of dependent children by an ex-spouse

Dropping Coverage

Direct Bill members may drop medical, dental and prescription coverage for themselves and/or any covered dependents at any time by notifying the Direct Bill Membership Office toll free at 1-866-541-7100 or 296-1715 (in Topeka).

Important: Once coverage has been terminated, the member cannot re-enroll at a later date. The effective date of termination will be the first day of the month following notification. When a member terminates his or her coverage, all dependents' coverage will be terminated as well.

Dental Coverage: Members can opt out of coverage during Open Enrollment only. Once a member opts out of dental coverage, the member will not be able to re-enroll in dental coverage at a later date.

Vision Coverage: Members can opt out of vision coverage during Open Enrollment only. Changes can be made to your coverage only when you or a dependent first becomes eligible, during the annual open enrollment period, or if a dependent becomes ineligible. **Mid-year changes to your vision coverage elections are not allowed.**

Dependent Definitions

Proof of Dependency and/or Residency

When enrolling a dependent for coverage with the State of Kansas Health Plan, the member must certify that a dependent meets the requirements for dependent coverage for the year in which the dependent is being enrolled. The member must also provide appropriate supporting documentation for each dependent. Any attempt to enroll dependent(s) who do not meet the requirements will be considered fraud and will be subject to penalties as prescribed by law.

Deceased Members and Spouses

In the event of a Direct Bill member's death, a family member or beneficiary should call the Direct Bill Membership Office as soon as possible to report the date of death. Prompt notification to the State of Kansas prevents additional premiums from being charged to the member's estate; however, the premium for the deceased member is still owed for the entire month in which the death occurs. If the premium is paid, health care claims for the deceased member will be paid up to and including the date of death.

If the Direct Bill member is covering a spouse and/or child(ren) as of the date of death, the surviving spouse and/or child(ren) will be offered continuous Direct Bill group health insurance coverage in his or her own name effective the first day of the month following the date of death. The premium for the remaining family members is generally lower; therefore, prompt notification to the Direct Bill Membership Office may reduce the premium cost.

If a spouse is deceased, the Direct Bill member should call the Direct Bill Membership Office as soon as possible to report the date of death. Premium for a single member is lower than for a member and spouse; therefore, prompt notification to the Direct Bill Membership Office will reduce the premium cost for the member. The premium for the deceased spouse is still owed

for the entire month in which death occurs. If the premium is paid, health care claims for the deceased spouse will be paid up to and including the date of death.

Mid-Year Change Requirements

Non-newly eligible members and/or dependents may be added to group health insurance coverage during the plan year but only if all of the following mid-year change requirements are met:

A. The change is a result of a qualifying event.

B. The change in coverage is consistent with the event.

C. Written documentation of the event (such as a marriage certificate, adoption papers or custody agreement) or a statement from spouse's employer is provided to the Direct Bill Membership Office.

D. The change is requested within 31 calendar days of the event by calling the Direct Bill Membership Office number listed in the "Contact Information" section.

E. A change form will be sent to the member for their signature. This form must be signed, dated and returned to our office for the changes to take effect.

Privacy Rights and Appointment of Personal Representative for Health Care Choices

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 gives you certain privacy rights with respect to health-related issues. More information about HIPAA may be found online at ***www.hhs.gov/ocr/hipaa*** (United States Department of Health and Human Services website) or ***www.medicare.gov*** (Medicare website).

As a health insurance provider for Direct Bill members, the State of Kansas is covered under HIPAA. As a result, we cannot discuss specific aspects of your health insurance coverage with anyone without your express written permission.

Therefore, if you need assistance in making health care decisions and wish to appoint someone to act on your behalf on health care issues, including your health plan choices, please go to ***www.kdheks.gov/hcf/sehp/Forms.htm*** to print the HIPAA Personal Representative form or contact the Direct Bill Call Center at 866-541-7100 (outside Topeka) or 785-296-1715 to have a form sent to you. Submit the completed form to Direct Bill Membership Services at Room 900-N, LSOB, 900 SW Jackson, Topeka, KS 66612 or by fax to **1-785-368-7180**. If you have already submitted this form, resubmission is not required unless you choose to make a change.

2014 DIRECT BILL OPEN ENROLLMENT PORTAL USER INSTRUCTIONS

Direct Bill members wanting to make changes to their State Employee Health Plan (SEHP) benefits for Plan Year 2014 must complete their open enrollment elections online.
Members will enroll online using any computer with Internet access – at work, home, or at most public libraries. Online enrollment is the only way to make changes to your Direct Bill coverage for 2014.

Starting November 1, 2013, you can visit the portal to verify your online account, review your contact information, review your current SEHP elections and then make any changes you want for 2014. The following information will provide you with step-by-step instructions on how to log on to verify your account and complete your open enrollment.

Prior to completing your online open enrollment you should review all your SEHP Open Enrollment 2014 materials to become familiar with your options. This includes this booklet and the Health Plan Comparison Charts.

If you have any questions regarding your benefit options, please contact our Direct Bill Benefits Consultants at 1-866-541-7100.

Before you begin, make sure you have the following information ready

- Your Social Security number (SSN)
- Your Date of Birth
- Your Kansas Employee ID number

Beginning November 1, 2013, if you have the information above, you are ready to log in, verify your account and complete your open enrollment elections for 2014.

1. Go to the Kansas employee eligibility portal at ***www.hrissuite.com***
2. The main login screen will appear. Enter your SSN, date of birth and Kansas employee ID number and click "Login".
3. The next screen will ask you if you are eligible for Medicare.
4. The next screen will ask you to verify your address, contact phone number and email address. You will be able to update these or add them at this time. These 3 items are required to continue with your open enrollment process. You will only be asked to review and verify these 3 items once during your open enrollment process.
5. You will then be taken to your personal account dashboard. This screen will show all your current family members and your current SEHP elections. If you wish to add or change any family member information, you may do so on this screen. After your review your current SEHP elections, if you want to continue the same benefit elections for 2014, you can select the button "Keep My Current Coverage". This will enroll you in the same benefit elections for 2014. If you wish to make changes to your SEHP benefits, select the button "Change My Benefit Elections" and follow the instructions on each screen to complete your enrollment.

6. Once you have completed your enrollment please make sure you save and submit your enrollment elections and print out a copy of your summary page for your records.

Please note: You may go into the enrollment portal as many times as you want during the Open Enrollment period (November 1 - November 30, 2013) and make changes. Benefit confirmation statements will be emailed directly to your registered email address each time you save an election in the portal. The SEHP benefits that you will be enrolled in January 1, 2014 will be based on the last enrollment elections that are in the eligibility portal as of midnight, November 30, 2013.

If you experience any technical trouble with this portal during open enrollment, call the Help Desk at:
1-800-832-5337 (Toll free)

The Help Desk is open:
Monday – Friday 7:00 AM to 7:00 PM
Saturday – Sunday 9:00 AM to 2:00 PM Central Time.

After hours:
Please e-mail: ***techsupport@hrissuite.com*** **-** Include your name, phone number, Kansas employee ID number and an explanation of your issue and we will trouble shoot your issue and contact you within 24 hours with a resolution.

Thank you for completing your Plan Year 2014 Direct Bill Open Enrollment Online!

Notes:

Notes:

KDHE-Division of Health Care Finance
STATE EMPLOYEE HEALTH PLAN
Room 900-N, Landon State Office Building
900 SW Jackson Street
Topeka, Kansas 66612

Presorted Standard
U.S. Postage
PAID
Permit No. 157
Topeka, KS

The Kansas State Employees Health Care Commission (HCC) reserves the right to suspend, revoke or modify the benefit programs offered to members. Nothing in this booklet shall be construed as a contract of employment between the employer and any member, nor as a guarantee of any member to be continued in the employment of the employer, nor as a limitation on the right of the employer to discharge any of its members with or without cause.

In this booklet, "you" refers to eligible members.